



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Houston Hospital for Specialized Surgery

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-14-0162-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Per the attached Surgery Scheduling Form Dr. Mark Henry deemed the patient's condition a **MEDICAL EMERGENCY** and with a time sensitivity of **WITHOUT DELAY**.

Amount in Dispute: \$8,076.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Texas Mutual argues this evidence does not support a medical emergency as define by Rule 133.2.

Response Submitted By: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2013	Outpatient Hospital Services	\$8,076.60	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment adjusted for absence of precert/preauth
 - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support definition of emergency?

2. Was preauthorization required?

Findings

1. 28 Texas Labor Code §133.2(5) states in pertinent part, "(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part;"

Review of the submitted medical record finds:

Surgery Scheduling Form, "NPO after 6am, Patient given arrival time – 2:00pm"

This procedure was scheduled not "sudden onset" as defined by Rule 133.2. Therefore the definition of emergency is not met.

2. 28 Texas Administrative Code §134.600 (p)"Non-emergency health care requiring preauthorization includes (2) outpatient surgical or ambulatory surgical services." Authorization was not requested. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	July 10, 2014 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.